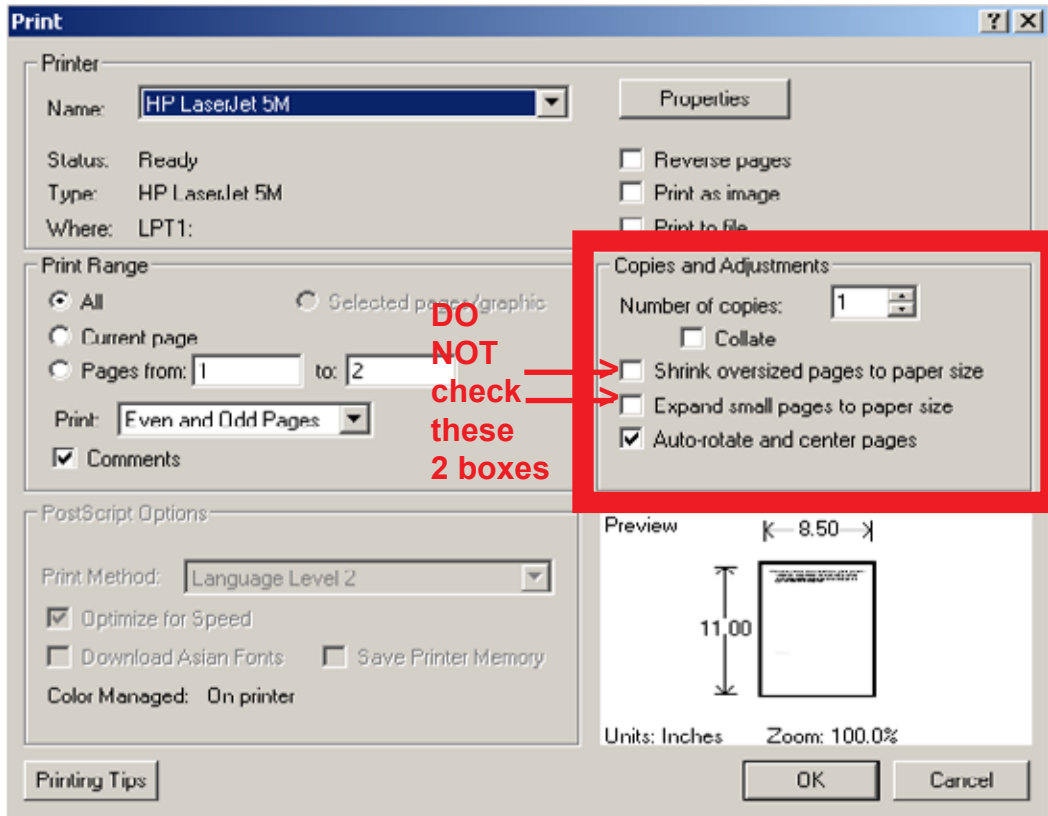


Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box "Auto-rotate and center pages." Do **not** check the Shrink or Expand boxes.



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Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Ocularist By Endorsement Application Packet

- 1. 678-017 ... Contents List/SSN Information/Deposit Slip 1 page
- 2. 678-016 ... Application For Credential As An Ocularist By Endorsement—Instructions..... 2 pages
- 3. 678-001 ... Application for Examination as an Ocularist 4 pages
- 4. 678-011.... Verification of Licensure—Ocularist..... 1 page

B. Important Social Security Number Information:

- * Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
- * Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

- 1. Complete the Deposit Slip below.
- 2. Cut Deposit Slip from this form on the dotted line below.
- 3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099.**



Cut along this line and return the form below with your completed application and fees.



Ocularist by Endorsement

DEPOSIT SLIP

NAME (Please Print) _____

DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return
with your application.

\$

- ☐ Check
- ☐ Money Order

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Application For Credential As An Ocularist By Endorsement—Instructions

An applicant holding a credential in another state may be credentialed in Washington State if the secretary determines that the other state's licensing standards are substantially equivalent to those currently applicable in Washington State.

Application Requirements

- ☐ 1. A completed application and forms provided by the secretary (see Application Breakdown).
- ☐ 2. Pay Application Fee of \$125.00. **(All fees are non-refundable)**
 - a. Fees may be paid with either a personal check or money order made payable to the Department of Health.
- ☐ 3. Documentation from the state in which the applicant is currently licensed sufficient to establish that the state's licensing standards are substantially equivalent to the licensing standards currently applicable in Washington State, to include:
 - a. A current copy of the law for each state in which an applicant holds a license.
 - b. Detailed information on the content of the required licensing examinations.
- ☐ 4. Verification from all states in which the applicant has ever held a license, whether active or inactive, indicating whether the applicant is or has been subject to charges or disciplinary action for unprofessional conduct or impairment.
- ☐ 5. One (1) passport-size (2" X 2" maximum) taken within one year of application. Sign and date the photo across the bottom and attach to application.
- ☐ 6. Official high school transcripts or equivalency from the issuing agency, forwarded directly to the Department of Health.
- ☐ 7. Four hours of AIDS training.

Application Components

☐ **Box #1: Demographic Information:**

Name: Please list your current name with middle initial.

Mailing Address: Please identify the address to which you wish all correspondence, including your credential, delivered. This will become your address of record for all Department of Health transactions until we are notified of a change.

Telephone Number: Enter current number where you may be reached during normal business hours.

Social Security Number: Required for licensure under 42 USC 666 and Chapter 26.23 RCW.

Additional Data: This information is required to update the Department's Database.

- ☐ **Box #2: Previous Licensure.** List *all* credentials you have held for practice as an ocularist in all states or other jurisdictions. List in chronological order, most current first. If you need additional space, attach on a separate piece of paper.
- ☐ **Box #3: Personal Data.** If you answer "yes" to any of the Personal Data Questions, you must submit the additional supporting documentation for that question, as indicated on the application. A "yes" response will not necessarily result in application denial, however, failure to honestly respond could be grounds to deny an application. Where specific statutes are indicated, be sure to read the appropriate statute prior to answering the question.
- ☐ **Box #4: AIDS Education and Training Attestation.** Required by WAC 246-12-040.
- ☐ **Box #5: Applicant's Attestation.** Required to be signed and dated in order to process the application. Please read thoroughly to ensure your understanding of the provisions in this section.

Make the fee payable to the Department of Health.

Fees must accompany the application and are non-refundable.

Applications and fees are to be sent to:

Department of Health
Ocularist Program
PO Box 1099
Olympia, WA 98507-1099

All other inquiries and documents should be directed to:

Department of Health
Ocularist Program
PO Box 47870
Olympia, WA 98504-7870

If you have any questions, please contact program staff at (360) 236-4948.



Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY

LICENSE #

ISSUANCE DATE

Application For Credential As An Ocularist☐ By Examination ☐ By Endorsement

Please Type or Print Clearly—Follow carefully all instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

All applications must be accompanied by the applicable fee. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME LAST FIRST MIDDLE INITIAL

RESIDENTIAL ADDRESS

CITY STATE ZIP COUNTY

NOTE: Your credentialing document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.) SOCIAL SECURITY NUMBER (Required for license under 42 USC 666 and Chapter 26.23 RCW)

()

GENDER BIRTHDATE (MONTH/DAY/YEAR) PLACE OF BIRTH (CITY/STATE)

☐ Female ☐ Male

/ /

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list other name(s):

Please indicate which applies to you: ☐ Completed High School ☐ General Education Development (GED)**2. Previous Licensure**

List all states or other jurisdictions where licenses were held.

| STATE/JURISDICTION | LICENSE TYPE | LICENSE NUMBER | LICENSE | | METHOD OF LICENSURE |
|--------------------|--------------|----------------|------------|-----------------|---------------------|
| | | | ISSUE DATE | EXPIRATION DATE | |
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License #

3. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain..... ☐ ☐

“Medical Condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered “yes” to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered “yes” to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered “yes” to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the ongoing treatment, and the factors in “1b” so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain..... ☐ ☐

“Currently” means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, and includes at least the past two years.

“Chemical substances” includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?..... ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances?..... ☐ ☐

“Currently” means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, and includes at least the past two years.

“Illegal use of controlled substances” means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The Department does criminal background checks on all applicants.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

a. the use or distribution of controlled substances or legend drugs?..... ☐ ☐

b. a charge of a sex offense?..... ☐ ☐

c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)..... ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ☐ ☐

b. committed any act involving moral turpitude, dishonesty or corruption? ☐ ☐

c. violated any state or federal law or rule regulating the practice of a health care professional? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If “yes”, explain and provide copies of all judgments, decisions, and agreements. ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ☐ ☐

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?..... ☐ ☐

4. AIDS Education and Training Attestation

I certify I have completed the minimum of four (4) of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS

5. Applicant's Attestation

I, _____, certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

SIGNATURE OF APPLICANT

DATE

Attach Current Photograph Here.
Indicate Date Taken and Sign in
Ink Across Bottom of the Photo.

NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

Official Use Only
Washington State Records Center



Health Professions Quality Assurance
Ocularist Program
P.O. Box 1099
Olympia, WA 98507-1099

Verification of Licensure Ocularist

TO APPLICANT: Complete top portion in full and forward to state in which you hold or have held a license/certificate as a Ocularist (there may be a fee for this service).

Name (Last, First, Middle Initial) _____

Street Address _____

City _____ State _____ Zip Code _____

License No. _____

I authorize the release of the information asked for below to the Washington State Ocularist Program.

Signature _____

It fees are the responsibility of the licensee named above.

TO STATE BOARD: The above individual is applying for licensure as an Ocularist in Washington State. To assist the Board in its review, please complete the following information and return to the above address. Thank you for your cooperation.

Name of Licensee _____

License No. _____ Date of Issue _____ Expiration Date _____

License was issued on the basis of:

☐ Examination in your state: ☐ Written Examination ☐ Practical Examination

☐ NEBO Examination

☐ Reciprocity/Endorsement from (indicate state)

☐ Registration (no examination required)

☐ Other (explain) _____

Legal/disciplinary action? ☐ Yes ☐ No

If yes, please explain _____

SIGNATURE OF VERIFIER

SEAL

TITLE

STATE BOARD

DATE